State of California Department of Consumer Affairs

**TELEPHONE MEDICAL ADVICE SERVICES BUREAU**
1625 North Market Blvd., Suite S-209
Sacramento, CA 95834
(916) 574-7992

# CONSUMER COMPLAINT FORM

***Please type or print legibly in ink and mail completed form to the Bureau at the address above.***

| **DETAILS ABOUT THE CONSUMER FILING THE COMPLAINT** | **PROVIDE DETAILS ABOUT THE BUSINESS THAT PROVIDED THE TELEPHONE MEDICAL ADVICE** | |
|---|---|---|
| NAME OF PERSON FILING COMPLAINT (COMPLAINANT) | NAME OF BUSINESS COMPLAINT FILED AGAINST | |
| STREET ADDRESS | STREET ADDRESS | |
| CITY/STATE/ZIP CODE | CITY/STATE/ZIP CODE | |
| PHONE WHERE YOU CAN BE REACHED 8am-5pm | PHONE NUMBER OF ADVICE PROVIDER | NAME OF PERSON THAT PROVIDED THE TELEPHONE MEDICAL ADVICE |
| DO YOU WANT YOUR NAME WITHHELD DURING THE INVESTIGATION? Yes ☐ No ☐ | | |

| SPECIFY MEDICAL ADVICE CONCERN | DATE OF SERVICE |
|---|---|
| BRIEFLY DESCRIBE YOUR COMPLAINT (BE SPECIFIC…. WHO, WHAT, WHEN, WHERE, HOW) USE ADDITIONAL PAPER IF NECESSARY | |
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***Reverse Side of this Form (Page 2) Must Be Completed***

***Please include as much detail as possible, as well as copies of any documents you have, such as patient records and correspondence that can be used as evidence (do not send original documents).***

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**Please type or print legibly in ink.** Please note that if you do not execute this release, the Telephone Medical Advice Services Bureau may not be able to investigate or forward the complaint.

Patient's Name: _____ Date of birth*: _____

I, the undersigned, have authority to authorize and hereby authorize

_____

Print name of telephone medical advice service

_____

Address

_____ _____

Telephone number Registration number

_____

Medical provider's name

to disclose the above named patient's medical information pertaining to telephone medical advice services provided to the patient to the Telephone Medical Advice Services Bureau of the Department of Consumer Affairs (Bureau). I understand that the Bureau may release these records to another government agency.

Medical information obtained pursuant to this authorization will be used for investigation into, and possible legal proceedings (administrative or otherwise) following, any violations of California laws and/or regulations.

I understand that I have a right to receive a copy of this authorization.

This authorization shall expire three (3) years from the date of signature below.

_____ _____

Patient's or legal representative's signature Date

If a legal representative is authorizing this release, please complete the following information:

_____ _____

Printed name of legal representative Relationship to Patient

*Date of birth is needed to positively establish the identity of the complainant.